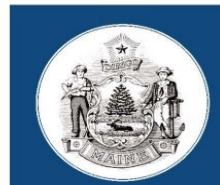




Medical Use of Marijuana Program
Patient Application/Renewal Form



John E. Baldacci, Governor

Department of Health
and Human Services

Maine People Living
Safe, Healthy and Productive Lives

Brenda M. Harvey, Commissioner

☐ \$100 Fee Enclosed

☐ \$75 Fee Enclosed MaineCare #: _____ (MaineCare # required for reduced fee)

Section 1 TO BE COMPLETED BY PATIENT

Name of patient (last, first, middle initial)

Check One:

☐ Grow my marijuana

Home Address
(number and street name)
(not required if homeless)

☐ Primary caregiver will grow marijuana

☐ Obtain marijuana from a registered dispensary

(city, state, zip code)

e-mail address:

Telephone: (207) -

Name of registered dispensary, if selected:

Mailing Address

Grow Location, if growing own marijuana

(city, state, zip code)

Date of Birth: _____ Driver License Number: _____ ☐ Copy of Driver License attached

If under 18 years of age, complete Section 2

Section 2 TO BE COMPLETED FOR MINOR APPLICANT in SECTION 1 OR PERSON UNDER GUARDIANSHIP OR DURABLE POWER OF ATTORNEY

Parent/guardian/other name (last, first, middle initial) as it appears on your driver's license

Telephone number if different than above

(207) -

Mailing Address if different than patient

☐ Parent with legal authority to make medical decisions

☐ Copy of Driver License attached

☐ Legal Guardian (attach copy)

Driver License Number: _____

☐ Durable Power of Attorney (attach copy)

Date of Birth: _____

Section 3 INDIVIDUAL PRIMARY CAREGIVER (other than a Registered Dispensary, Nursing Facility or Hospice)

Name (last, first, middle initial) as it appears on Driver License, or legal name

Telephone number: (207) -

Home Address

(street)

(city, state, zip code)

Mailing Address

(city, state, zip code)

e-mail address:



☐ Signed release of information to speak with your physician and/or primary caregiver is attached

Describe the nature of the assistance to be provided by person named in Section 3, if you have designated a primary caregiver.

☐ Grow my marijuana ☐ Transport my marijuana from their grow site to my home ☐ Help me use my marijuana

☐ Help me prepare my marijuana into a form for ingestion ☐ Acquire my marijuana from a dispensary ☐ Assist me to take my

marijuana ☐ Other

Section 3 NURSING FACILITY OR HOSPICE PROVIDER AS CAREGIVER

If you choose a nursing facility or hospice to assist you, please indicate the name:

Contact person at the facility:

☐ Check if hospice

☐ Check if nursing home

Declaration: I understand and acknowledge my duty as a patient. I understand that if my card is revoked, is voided or expires, my caregiver's identification card will be void. If I choose another primary caregiver, I must notify you and the primary caregiver card will be null and void and will be returned to the Department of Health and Human Services. I declare under penalty of perjury that the information provided on this form is true and correct. I certify that I will not sell, furnish or give marijuana to a person who is not allowed to possess marijuana for medical purposes, except as provided un the Maine Medical Use of Marijuana Act, and its rules.

Printed name of patient

Date

Signature

Printed name of person legally responsible

Date

Signature

**Maine Medical Use of Marijuana Program
Maine Department of Health and Human Services
Division of Licensing and Regulatory Services
41 Anthony Avenue, SHS #11
Augusta, ME 04333-0011**

Release of Medical Information

As part of an application for a registry identification card to lawfully possess and/or obtain marijuana for medical use, the condition for which a physician recommends the use of marijuana for medical purposes must meet certain requirements provided by law.

I hereby give permission to a representative of the Maine Medical Use of Marijuana Program, Division of Licensing and Regulatory Services, Department of Health and Human Services, to request information from the physician(s) who has made that recommendation for medical use of marijuana to determine that it meets statutory requirements.

Date: _____

Patient's Name

Patient's Signature

Or Legal Guardian's Name (if applicable)

Guardian's Signature

Name of Physician